HUMAN SERVICE PROVIDER RATES

A Report Prepared for the

Legislative Finance Committee

by

Carroll South

Senior Fiscal Analyst

November 20, 1992

Legislative Fiscal Analyst

EXECUTIVE SUMMARY

In fiscal 1993, $357.3 million ($105.4 million general fund) has been appropriated to three state agencies to purchase services from private contractors providing mental health, developmental disabilities (DD), foster care, day care, medical, and other human services. The general fund appropriated for this purpose is the third largest component of the state general fund budget, accounting for 19.8 percent of total anticipated general fund expenditures in fiscal 1993, and is more than double the amount appropriated for operations and equipment for all executive, legislative, and judicial agencies. More than 77 percent of the total funds appropriated to purchase human services will be paid to providers participating in the medicaid and state medical programs.

General fund contracted to purchase human services from private providers has increased as a percentage of total general fund expenditures, primarily due to rapid growth in medicaid expenditures, which grew from 9.7 percent of total general fund expenditures in fiscal 1989 to an estimated 12.9 percent of the total in fiscal 1993. Expenditures for primary care medicaid (hospitals, physicians, dentists, etc.,) increased more than 20 percent per year from fiscal years 1989 through 1992. Also contributing to growth in provider payments is the continued down-sizing of state facilities, which results in a shift of funds from state agency operational budgets to private providers.

Using a variety of methodologies, state agencies establish the rates they pay for most services purchased from providers. Although some rates set by the agencies are not increased without specific legislative authorizations, others may increase as the providers' allowable costs increase. This dual rate-setting process may be flawed because: 1) some providers receive rate increases without legislative authorization, while others must defend their rate increases to the legislature; 2) it may limit the legislature's ability to establish its own priorities for rate increases; and 3) it may reduce the legislature's ability to control costs by denying it the opportunity to approve certain rate increases.

The Office of Budget and Program Planning (OBPP) and the Legislative Fiscal Analyst (LFA) utilize a well-defined "current level" budgeting process to develop state agency operational budgets. The process provides for budgeting inflationary increases to reflect agencies' estimated cost of providing current service levels during the next biennium. However, no such system exists for establishing contracted service budgets for agencies that purchase human services from private contractors. The current level budgeting process makes no allowance for increased costs the providers will incur in providing the same level of service to the agencies during the next biennium.

While state agencies are required to request "budget modifications" only to expand programs, increase service levels, or increase staff, nearly all provider rate increases requested by agencies are considered "budget modifications", even if the increase is intended to cover the same inflationary costs included in state agency current level budgets. The requirement that most provider rate increases be

budgeted as modifications, rather than current level adjustments, may be flawed because: 1) the executive may not request rate increases to cover inflation if the increases are perceived as "expansions" of state government; and 2) the public may be given the misleading impression that government is expanding when the legislature approves increases intended to cover only the increased costs incurred for providing the same service levels.

Moreover, because there is no current level budgeting process for human service provider contracts, the OBPP and LFA perform no analysis of existing rates and costs and may not be able to provide the legislature with data it needs if it wishes to consider rate increases. The lack of a current level budgeting process for provider contracts may result in: 1) legislative approval of across-the-board provider rate increases that may have little relationship to increased costs; 2) different provider groups receiving different increases, not because one's costs will increase more than the others, but because different appropriations subcommittees considered the increases; and 3) fixed cost increases "eating" up most or all of any rate increase, leaving little, if any, funding to increase salaries of provider employees.

The legislature may wish to consider the development of a current level budgeting process for appropriate human service provider contracts that is similar to the process now used to develop state agency operational budgets. The process could be designed to develop aggregate expenditure levels for provider contracts by utilizing many of the same inflation factors used for state agency budget development. Non-state provider revenue sources (eg., resident room and board payments and fees-for-service from non-state entities) would be estimated and applied against the aggregate funding level to determine the state's share of the increased costs.

PURPOSE

The purpose of this report is to provide the Legislative Finance Committee information regarding:

1) the amounts spent by the state to purchase services from different types of human services providers;

2) methods used by state agencies to set human service provider rates;

3) methodologies used by the OBPP and LFA to develop budgets for human service provider contracts prior to legislative sessions; and

4) options that may provide a more systematic way of budgeting for and funding rate increases for human service providers.

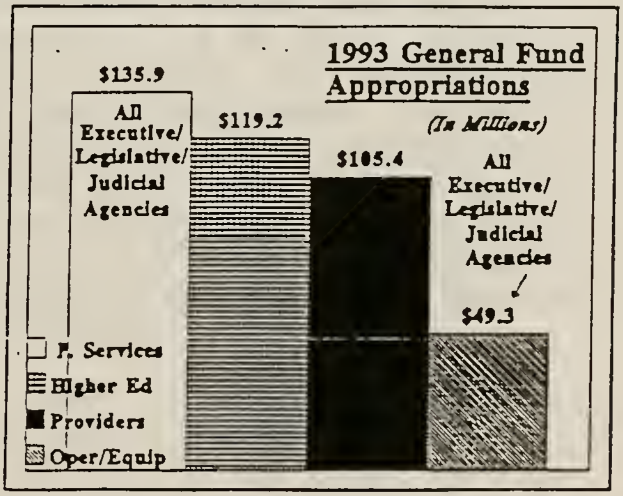
INTRODUCTION

The state contracts with many provider types to deliver human services, such as developmental disabilities, mental health, inmate pre-release, and medical services. The legislature appropriated $357.3 million ($105.4 million general fund) in fiscal 1993 to purchase these services as shown in Table 1.

TABLE 1
Fiscal 1993 Provider Appropriations

Service Type	Total Funds	General Fund	% Of Total
Medicaid [(A)(B)]	$271,271,827	$66,745,032	75.91%
Developmental Disabilities	33,458,637	13,198,378	9.36%
Foster Care [(A)]	17,922,807	11,271,024	5.02%
Vocational Rehabilitation	6,986,033	1,256,964	1.96%
Day Care	6,175,603	979,776	1.73%
Mental Health	5,440,800	4,419,934	1.52%
Aging	4,764,639	643,246	1.33%
State Medical	4,384,000	4,384,000	1.23%
Welfare Work/Training	3,335,894	1,041,505	0.93%
Chemical Dependency	2,354,476	213,300	0.66%
Inmate Pre-release	1,246,867	1,246,867	0.35%
Total	$357,341,583	$105,400,026	100.00%

(A) Includes anticipated supplemental appropriations
(B) Excludes state institutions/medicare buy-in & Indian Health Care pass-throughs



General fund appropriated to contract with human services providers is the third largest component of the state general fund budget. The $105.4 million general fund appropriated for this purpose in fiscal 1993 accounts for 19.8 percent of total anticipated general fund expenditures and is only $13.8 million less than the general fund appropriated to fund all higher education agencies. While fiscal 1993 general fund appropriations for human service provider contracts are $30.5 million less than general fund personal services appropriations to all executive, legislative, and judicial agencies, they are more than double the amount appropriated to these agencies for operations and equipment.

In recent years, expenditures for contracts with human services providers have increased as a percentage of total general fund expenditures, largely due to growth in medicaid expenditures. General fund expenditures for medicaid increased from 9.7 percent of total general fund expenditures in fiscal 1989 to an estimated 12.9 percent of the total in fiscal 1993. Expenditures for primary care medicaid services (hospitals, physicians, dentists, etc.) increased 20.8 percent from fiscal 1989 to fiscal 1990; 22.7 percent from fiscal 1990 to fiscal 1991; and 28.1 percent from fiscal 1991 to fiscal 1992. These large increases were caused by increases in costs per unit of service, caseloads, and service utilization.

Another factor contributing to growth in human services provider payments is the continuing down-sizing of state institutions. The 1989 and 1991 legislatures approved the transfer of 84 residents from the Montana Development Center to community-based facilities. This trend is likely to continue in the near future because: 1) the January 1992 special legislative session authorized the transfer of $1.0 million in personal services funding from the Montana State Hospital (MSH) to community-based services to comply with a court-ordered plan to downsize MSH; and 2) the executive plans to request that the 1993 legislature approve a plan to increase community-based corrections facilities, rather than constructing additional housing units already authorized at Montana State Prison.

While the state's overall costs may not be reduced significantly when residents move from state to private facilities, the expenditure mixture changes as funds are shifted from state agencies to private providers. With increased numbers of individuals residing in community, rather than state facilities, the contracted expenditure base becomes larger and rate increases granted the providers will cost more and play a bigger role in the budget-balancing process.

As the private sector expands to supply additional services to the state, they may become more dependent upon systematic review and adjustments of the rates they receive. When the state is only one of many customers purchasing services from a provider, state reimbursement rates may not have a major impact on the provider's revenues because costs may be shifted to other customers. However, if state reimbursement provides most, or all, of a provider's revenues, state rates have a critical impact on the provider's operations and survival. If state rates do not keep pace with these providers' increased costs, they may be forced to reduce service levels because there is no third party to whom the facilities can shift costs. If providers fail because state rates have not kept pace with their costs, the state will still be required to house, treat, and care for those clients for whom it is responsible.

AGENCY RATE SETTING METHODOLOGIES

Corrections & Human Services

Mental health centers - The Department of Corrections and Human Services (DCHS) contracts with mental health centers on a fee-for-service basis to provide services to persons diagnosed as seriously mentally ill. Many of these individuals may have been hospitalized at MSH or would be at risk of hospitalization if they did not receive services from the centers. The agency also used a fee-for-service rate to purchase services for persons diagnosed with a non-serious mental illness until fiscal 1992, at which time it began allocating funds to each of the five regions to provide services to these individuals.

In general, the rates take into account revenues collected by the centers from persons with serious mental illness and the number of service units provided to this group paid for by medicaid. Each center is reimbursed based on: 1) its individual fixed costs, at the median rate of all centers for its variable costs; and 2) its net rate adjusted by the median revenue collections from persons with serious mental illness of all centers. Other adjustments may also be made as necessary.

Although DCHS has not requested funding for a rate increase for mental health centers in its 1995 biennium budget submitted to OBPP, it plans to increase rates paid the centers during the next biennium using the established rate-setting methodology. If rates are increased without additional funding, the agency will be forced to purchase fewer services for the seriously mentally ill or reduce the funding allocation for services delivered to persons who are not seriously mentally ill.

Pre-release centers - DCHS also contracts with pre-release centers to house and supervise prison inmates nearing the completion of their sentences. From fiscal 1985 through 1992, each center was paid a different rate based on its costs. To ensure that the facilities' fixed costs were covered, each center's daily rate increased when fewer inmates were housed in the facilities. Beginning in fiscal 1993, the three centers each receive the same rate, which is no longer adjusted for changes in population. A fourth pre-release center, opened in fiscal 1993, will be paid at a commensurate rate, effective fiscal 1994.

DCHS has not requested funding for a rate increase for pre-release centers in its 1995 biennium budget submitted to OBPP and does not plan to increase the rates during the next biennium. However, the executive does plan to ask the 1993 legislature to expand community-based correction facilities, rather than expanding the prison at Deer Lodge.

Family Services

Foster care - The Department of Family Services (DFS) contracts with several different provider types to care for foster children and adolescents. The 1987 legislature, concerned about inequitable reimbursement for foster care services, instructed the agency to develop a "model" rate structure for shelter care, group homes, and residential treatment facilities. The 1989 legislature appropriated $3.3 million to bring these providers up to 100 percent of the model rate in fiscal 1991 and increased family foster care rates 2.0 percent each year of the 1991 biennium. The 1991 legislature increased funding for foster care rates by 4.5 percent each year of the 1993 biennium.

Except for rates paid inpatient residential psychiatric facilities (which are covered under the state medicaid program), the agency increases foster care rates only when additional funding is authorized by the legislature. DFS has not requested funding for a rate increase for foster care providers in its 1995 biennium budget submitted to OBPP and does not plan to increase the rates during the next biennium.

Day care - DFS also contracts for day care services and sets the day care rates providers receive. There are three levels of day care services for which the agency establishes rates: 1) family day care; 2) group care; and 3) day care centers. The agency increases the rates only when the legislature authorizes additional funding. The 1989 legislature authorized increases of $0.50 per day in 1990 and $1.00 per day in 1991. The 1991 legislature authorized fiscal 1992 increases of $1.00 per day for family and group providers and $0.50 per day for day care centers. In fiscal 1993, family providers were authorized an additional $0.75 per day and group providers an additional $0.25 per day. DFS has not requested funding for a rate increase for day care providers in its 1995 biennium budget submitted to OBPP and does not plan to increase the rates during the next biennium.

Social & Rehabilitation Services

Developmental disabilities - The Department of Social and Rehabilitation Services (SRS) contracts with approximately 50 organizations to provide community-based services to an estimated 3,000 persons with developmental disabilities. Services purchased include residential services, supported employment, and vocational services. While DD providers of some services are paid on a fee-for-service basis, most are paid based on the actual costs they incur, subject to an upper limit. The fee-for-service rates were established by the agency and providers several years ago and are increased only when the legislature appropriates additional funding for that purpose. Cost-based rates are capped at the previous year's rate unless the legislature appropriates additional funding.

The 1987 and 1989 legislatures appropriated funding for annual rate increases of 2.0 percent for DD services during the 1989 and 1991 biennia. The 1991 legislature appropriated funding for annual rate increases of 4.5 percent during the 1993 biennia. SRS has not requested funding for a rate increase for DD providers in its 1995 biennium budget submitted to OBPP and does not plan to increase the rates during the next biennium.

Vocational rehabilitation/visual services - SRS also purchases services from private providers for persons needing vocational rehabilitation and visual services. While this program sets the rates paid to some providers, it pays other providers their billable rates. The program uses the medicaid fee schedule when purchasing medical services if the provider will accept the medicaid rate. The program also purchases educational services from the university units, paying tuition and fees set by the university system.

The 1989 legislature appropriated funding for annual rate increases of 2.0 percent for these providers during the 1991 biennium and the 1991 legislature appropriated funding for annual rate increases of 4.5 percent during the 1993 biennium. Although SRS has not requested funding to increase these provider rates in its 1995 biennium budget submitted to OBPP, many rates may still increase because the program purchases goods and services from providers who set their own rates. When rates increase without additional funding, the program is forced to reduce the number of services it purchases.

Medicaid/state medical - Although the medicaid program is operated under federal law, SRS sets the rates paid medicaid providers and uses the same rates in the state medical program. The state will spend approximately $229.9 million ($57.4 million general fund) in fiscal 1992 to purchase services from medicaid providers. Table 2 shows estimated fiscal 1992 medicaid expenditures by service type. State institutions reimbursement, Indian Health Care pass-through and medicare buy-in expenditures are not included.

TABLE 2
Fiscal 1992 Estimated Medicaid Expenditures

Service Type	Total Funds	General Fund	% Of Total
Nursing Facilities	$67,091,926	$18,980,306	29.19%
Inpatient Hospital	51,893,589	(A) 7,089,767	22.58%
Physicians	26,024,419	7,362,308	11.32%
Miscellaneous (B)	25,333,649	7,166,889	11.02%
Outpatient Hospital	15,774,920	4,462,725	6.86%
Prescription Drugs	15,159,663	4,288,669	6.60%
Inpatient Psychiatric	14,464,085	4,091,890	6.29%
Waiver (C)	5,835,134	1,650,759	2.54%
Dental	4,160,314	1,176,953	1.81%
Other Practitioners (D)	4,125,501	1,167,104	1.79%
Total	$229,863,200	$57,437,370	100.00%

(A) Does not include $7.6 million state special revenue used in lieu of general fund.
(B) Includes mental health, personal care, medical equipment, and case management.
(C) Provides home-based services to persons who otherwise might be admitted to nursing facilities.
(D) Non-physician practitioners, such as psychologists, social workers, and optometrists.

The different methodologies SRS uses to set medicaid rates are discussed below. *Fee-based services* - The agency establishes fee schedules by rule for nearly all services it purchases from individual providers, such as physicians, dentists, psychologists, and pharmacists dispensing fees. In many cases, the rules state that the rate will not be increased without specific legislative authorization. The last general rate increase for this group of providers was a 2.0 percent annual increase in the 1991 biennium authorized by the 1989 legislature. However, the 1991 legislature authorized significant increases in three types of services provided by physicians. SRS has not requested funding for a rate increase for this group of providers in its 1995 biennium budget submitted to OBPP and does not plan to increase the rates during the biennium.

Negotiated contracts - Several medicaid services are purchased through negotiated contracts. In some instances, such as personal care and waiver services, the agency may issue Requests For Proposals (RFP) and chose a provider from those submitting a proposal. The agency may negotiate with the successful bidder to lower the proposed rates or make other adjustments if necessary. Services from mental health centers are purchased at contracted rates that reflect the allowable costs of the five centers. Rate increases for these providers will be part of the 1995 biennium current level medicaid budget.

Inpatient medical hospital services - Inpatient medical hospital services are reimbursed based on diagnostic related groups (DRG's) that tie reimbursable costs to the diagnosis of the patient. However, federal law requires that the per diem

rates paid medical hospitals be "reasonable and adequate." The 1991 legislature appropriated funding for a 5.62 percent increase in inpatient hospital rates, effective October, 1992, but, at the request of the executive, the January 1992 special session eliminated funding for the increase. Based on a recent study of inpatient medical hospital costs conducted by a contracted firm, SRS has requested additional funding in its 1995 biennium budget to increase inpatient medical hospital rates.

Psychiatric/outpatient/prescription drugs - All inpatient psychiatric hospital and residential services, prescriptions drugs (excluding the dispensing fee paid the pharmacist), and most outpatient hospital services are reimbursed on an "allowable" cost basis. These rates will increase during the 1995 biennium without legislative authorization if allowable costs increase.

Nursing facilities - Prior to the 1991 legislative session, the agency commissioned a study that determined fiscal 1991 medicaid rates paid nursing facilities were approximately $8.57 per day less than the average cost of providing nursing care. The 1991 legislature appropriated $22.2 million ($6.2 million general fund) in additional funding during the 1993 biennium to phase in a re-basing of medicaid nursing facility rates. The re-basing was intended to bring medicaid rates more in line with actual costs by using more recent nursing facility cost data.

The agency used the following methodology to set nursing facility rates in fiscal 1993. Each facility's base period was its cost report period of at least six months with a fiscal year ending between January 1, 1991 and December 31, 1991. Nursing facility base period costs were divided into three components: 1) operating costs, which include administrative, laundry and housekeeping; 2) direct nursing personnel costs, which include salaries and benefits for registered nurses, licensed practical nurses, and nurses aids; and 3) property costs, which include building and equipment depreciation, building and equipment leases, and certain interest costs.

1) The operating component of each nursing facility's rate is the <u>lesser</u> of: a) its allowable operating costs for the base period inflated to the current year using McGraw-Hill nursing facility inflation indices; or b) 110 percent of the median per bed day operating costs for all licensed nursing beds in the state. If the facility's inflated base operating costs are less than 110 percent of the median, an incentive allowance is granted equal to the <u>lesser</u> of: a) 5 percent of the median operating costs; or b) 40 percent of the difference between the facility's inflated operating cost and the median operating costs.

2) The direct nursing component of each nursing facility's rate is the <u>lesser</u> of: a) the facility's composite nursing wage rate in its base period inflated to the current year using McGraw-Hill nursing facility inflation indices times the facilities most recent average patient assessment score; or b) 125 percent of the median average wage per bed day times the facilities most recent average patient assessment score. (Patient assessment scores are used to determine the level of care required by nursing residents in a facility.)

3) Property costs for all facilities are capped at $9.47 per bed day. Rates for individual nursing facilities were calculated as follows.

a) If the facility's base period allowable property costs were less than its fiscal 1992 rate, its property cost component is the <u>lesser</u> of its 1992 rate or $9.47 per bed day.

b) If the facility's base period allowable property costs exceeds its fiscal 1992 rate by more than $0.57 per bed day, its property cost component is its 1992 rate plus $0.57 per bed day.

c) If the facility's base period allowable property costs exceeds its fiscal 1992 rate by $0.57 per bed day or less, its property cost component is its base period allowable costs.

In addition to the limits described above for the operating, direct nursing, and property cost components, a nursing facility's total fiscal 1993 rate may not exceed its total fiscal 1992 rate by more than $6.00 per day.

The range of each facility's fiscal 1992 medicaid rate (the first year of the re-basing approved by the 1991 legislature) was limited to a minimum of 5.5 percent above its fiscal 1991 rate and a maximum of $8.00 per day above its fiscal 1991 rate. SRS has not requested funding for a rate increase for nursing facilities in its 1995 biennium budget submitted to OBPP and does not plan to increase the rates during the next biennium.

EXECUTIVE/LEGISLATIVE BUDGETING

Non-Medicaid Services

<u>Current level budgeting methodology</u> - State law defines a "current level" budget as the "level of funding required to maintain operations and services at the level authorized by the previous legislature, after adjustment for inflation". A well-defined methodology exists to develop state agency "current level" operating budgets. The OBPP and LFA agree on the "base" year, inflation factors, and a personal services "snapshot", reflecting current staffing levels. Increases for inflation automatically become part of agency current level budgets as do increases in workers' compensation, social security, and unemployment; agencies are not required to request or justify these increases. When the legislature reviews state agency current level budgets, they have been increased to reflect the estimated cost of agency operations during the next biennium under current law.

In contrast, current level budgets for contracted human services providers remain at the level established by the previous legislature with no adjustment for inflation. Current funding levels for these contracts are not increased, even though the

providers may incur the same inflation and workers' compensation increases as state agencies during the next biennium. Providers and the agencies with which they contract must request and justify as "budget modifications" the same inflationary increases for providers automatically built into state agency current level budgets. During the last three biennia, nearly all rate increases granted community providers have been considered and appropriated as budget modifications.

Budget modification criteria - State agencies are required to submit budget modification requests only to expand programs, increase service levels, or increase staff. These requests are presented separately from the current level in the Executive Budget, not included in the LFA current level budget, and considered an "expansion" of state government because they expand services and/or staffing levels. The increases are clearly identified in narrative accompanying the appropriations bill throughout the legislative process and are considered to be "growth" above current level. Requiring that all provider rate increases granted to cover increased costs of providing the same level of services be considered and funded as budget modifications may give a misleading impression that state government is expanding when it is not.

Further, requiring all provider rate increases to be considered budget modifications, rather than current level adjustments, may shift the responsibility for funding the increases from the executive to the legislature. State agency current level inflationary increases are included in the Executive Budget, a process that requires the executive to "fund" inflation because the budget must be balanced. However, the executive makes no current level adjustments for provider contracts and is required to fund them only if it requests budget modifications to increase the rates. (The executive did not include rate increases in its 1993 biennium budget and the affected state agencies have not requested increases for the 1995 biennium.) This process forces the legislature to fund rate increases if it chooses to grant them by finding additional revenues, reducing proposed executive spending elsewhere, or reducing the ending fund balance to provide rate increases.

Across-the-board percentage increases - Because the OBPP and LFA do not review funding for provider contracts during the budget development process, the legislature may not have the information it needs to determine appropriate funding levels for provider contracts. During the last three biennia, the legislature approved across-the-board percentage increases to most of these providers, rather than increases based on an analysis of increased costs. Because inflation has not been estimated (as it has for state agencies), the rate increases granted may have had little relationship to increased costs. Additionally, lack of appropriate data may lead to varying percentage increases for different provider groups, not because inflation is greater for one group than another, but because different subcommittees approved the increase.

For example, the 1991 legislature approved 4.5 percent annual increases for DD, vocational rehabilitation, and foster care providers, while providing 2.0 percent annual increases for mental health and pre-release providers. The human services

subcommittee approved 4.5 percent increases, while the institutions subcommittee approved 2.0 percent increases. There is no evidence suggesting that the rate increases approved varied because any provider group's costs were anticipated to increase more than others. Further, during the July 1992 special session, the 2.0 percent increase for mental health centers in fiscal 1993 was eliminated but the other provider rate increases were left intact.

Moreover, even when providers are granted the same percentage rate increase, they may still be treated differently because the increases have not been based on estimates of increased costs. For example, the 1989 legislature approved 2.0 percent annual increases for the mental health and pre-release centers during the 1991 biennium. However, despite the fact that the same state agency contracts with both provider groups and the same subcommittee approved the increases, the conditions under which the rate increases were granted were different for each group. The legislature expressed its intent that the 2.0 percent rate increase granted to mental health centers <u>not</u> be considered part of the current level budget during the 1993 biennium, while imposing no such requirement on pre-release center budgets. This action forced the executive to request a budget modification for funding already built into the mental health center rates.

<u>Private provider pay increases</u> - The legislature has periodically attempted to maintain some relationship between the salary levels of state employees and private employees performing the same work on behalf of the state. The 1985 legislature appropriated additional funding commensurate with state employee salary increases for contracts with mental health centers during the 1987 biennium, and the 1989 legislature did the same for pre-release centers during the 1991 biennium. The 1989 legislature also appropriated an additional $2.5 million to increase DD community-based direct care salaries during the 1991 biennium. Without a current level budgeting methodology for human services provider contracts, the legislature cannot be assured that any relationship between state and private employee salary levels is maintained.

Because providers' fixed cost increases are not estimated and funded in current level budgets, most of any across-the-board percentage increase granted to providers may be required to cover the provider's increased costs and not be available for salary increases. After reviewing a sample of DD provider budgets, SRS staff found that several DD providers will spend from 53 percent to 97 percent of the 4.5 percent rate increase provided them during the 1993 biennium to cover increased workers' compensation and health insurance costs. When the providers' fixed cost increases are funded, there may be little funding left to increase DD direct care workers' salaries. In contrast, a state agency's current level budget contains funding to cover increased operational and payroll costs and additional funding is provided for state employee salary increases.

Medicaid Providers

Medicaid rates can be categorized in two ways: 1) those that increase without legislative authorization; and 2) those that do not. Because the legislature does not control many rates and historically has not limited numbers of recipients and services, the current level budgeting methodology used by the OBPP and LFA for medicaid is more an estimate than a budgeting process. While there is no well-defined process for establishing inflation factors or growth in recipients and services, the OBPP and LFA have agreed to present the 1993 legislature with a joint estimate for the current level medicaid budget.

This joint estimate is agreed to after the OBPP, LFA, and SRS, each using different methodologies, estimate medicaid expenditures for the fiscal year in which the legislature meets. An inflation factor reflecting increases in costs, recipients, and services is then applied to that estimate to generate the current level budget for the next biennium. Because very little data is available for the "base" year when the estimates are made and growth is unpredictable, it is difficult to develop a medicaid budget with any degree of accuracy. If the estimated budget approved by the legislature is inadequate, a supplemental appropriation will be required because the program is an "entitlement".

Current level versus budget modification - The distinction between current and modified level budgets is blurred in the medicaid program, both in terms of rate increases and program expansion. Some providers may receive rate increases for some services in current level and others may not, depending upon how SRS sets the rates. For example, the 1991 legislature approved budget modifications to increase rates for nursing facilities, ambulances, and certain services delivered by physicians. These rates would not have increased without legislative approval and additional funding. However, rates for inpatient psychiatric and outpatient hospital services and certain other services are increased by SRS without legislative authorization because they are either cost-based or established by negotiated contract.

While current level budgets for community-based providers of DD, mental health and inmate pre-release services are limited to the number of recipients and services approved by the last legislature, the current level medicaid budget funds both increased caseloads and services. The number of medicaid recipients cannot be capped under federal regulations and, except for a few types of services, the state does not impose limits on the number of services any medicaid recipient may receive. Budget modifications in the medicaid program are requested only to expand services to a new group of recipients or to provide a new service.

The existing medicaid budgeting and rate-setting process may tend to favor some provider groups and services over others. Rate increases for nursing facilities, inpatient hospital services, and most fee-based providers must be presented to and acted upon by the legislature. However, rate increases for certain cost-based facilities, such as psychiatric and outpatient hospital services and negotiated contract,

such as personal care, and mental health center services are not presented to the legislature; and the legislature may not be aware that increased rates for these providers are funded in the current level medicaid budget. This process reduces the legislature's ability to establish its own priorities for providing rate increases to medicaid providers and may reduce its ability to control medicaid costs.

Recent Rate Increases

Table 3 shows the rate increases budgeted for various provider groups during the last three biennia as recorded in the Appropriations Report for each biennium.

Table 3

Budgeted Provider Rate Increases

Provider Type	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
Physicians	1.5%	1.5%	2.0%	2.0%	(A)	(A)
Nursing	2.0%	2.0%	(B) 3.0%	(B) 3.0%	9.9%	4.8%
Hospitals	0.0%	0.0%	3.9%	3.9%	0.0%	0.0%
Other Medicaid	0.0%	0.0%	2.0%	2.0%	0.0%	0.0%
Mental Health	0.0%	0.0%	2.0%	2.0%	2.0%	0.0%
Pre-Release	0.0%	0.0%	(D) 2.0%	(D) 2.0%	2.0%	2.0%
Foster Care	2.0%	2.0%	(E)	(E)	4.5%	4.5%
DD	2.0%	2.0%	(F) 2.0%	(F) 2.0%	4.5%	4.5%

(A) Obstetrical/gynecological services from 50% to 85% of allowable costs. Pediatric services from 50% to 80% of allowable costs. No increase for other services.
(B) Also received $390,209 in FY90 and $803,830 in FY91 to increase nurse aides salaries.
(C) Approximate average increase net of nursing home bed fee imposed by HB 93.
(D) Also received additional funding commensurate with state employee pay plan.
(E) Non-family foster rates to 100% of model. Family foster care rates increased 2%.
(F) Also received additional funding to increase direct care staff salaries.

BUDGETING METHODOLOGY OPTIONS

Problems With Current Methodology

Non-medicaid providers - A "current level" budget is defined in state law as the "level of funding required to maintain operations and services at the level authorized by the previous legislature, after adjustment for inflation". The OBPP and LFA budgeting systems are currently applying inflation factors to more than 80 different expenditure items and including increases in workers' compensation rates in state agency current level budgets to be presented to the 1993 legislature. However, neither office is using a comparable system to adjust budgets for human service provider contracts for "inflation". Consequently, the 1993 legislature will

act on current level budgets for all non-medicaid providers at the actual dollar level established by the 1991 legislature.

Moreover, because the responsible state agencies are not requesting rate increases for these providers and there is no analysis of these budgets by the OBPP and LFA, the 1993 legislature may not have adequate data available if it wishes to increase provider rates based on increased costs. Historically, a lack of cost data for these providers has resulted in the legislature approving across-the-board rate increases that may have had little relationship to inflation.

Without a well-defined process to make inflationary adjustments in current level budgets for purchasing human services, the legislature cannot be assured that any portion of rate increases it grants providers will be available to increase private provider employee salaries. Providers must pay their fixed costs, but may be able to postpone salary increases if adequate funding is not available. If most or all of any rate increase granted them is "eaten" by fixed costs that have not been included in their current level budgets, there may be little funding left for salary increases.

<u>Medicaid providers</u> - The existing current level budgeting process for medicaid providers may be inadequate in at least two ways. First, there is a disparity in the way rate increases are granted to different providers. Providers whose rates are not increased without specific legislative authorization must justify any rate increases through the budget modification process, while other providers do not. The current level medicaid budget approved by the legislature funds rate increases for some providers but not others.

Second, because there is no current level system for reviewing many medicaid provider rates, the legislature may not have the information it needs if it wishes to increase provider rates that are not based on cost. While SRS does periodically analyze costs for delivering inpatient hospital and nursing facility services and must review cost data before setting rates for cost-based facilities, there is no systematic review of most providers' rates based on a fee-for-service.

Improving The Budgeting System

<u>Non-medicaid services</u> - Providers who operate facilities such as mental health/DD/foster care group homes and pre-release centers provide many of the same services provided at state facilities and incur cost increases similar to those incurred by state facilities. Additionally, if the legislature wishes to maintain some degree of parity between state and private employees doing the same type of work, salary schedules for employees of these providers types are available for comparison. It may be possible to develop current level budgets for these contracts in the following manner:

1) A base year would be selected for each provider group. Depending upon the level of detail available in provider base year budgets, inflation factors used for state agency operational budgets would be applied to the same expenditure items in provider budgets. Estimates of increases in mandatory employee benefits would be made, as would estimates of other factors which may increase costs but not be covered by specific inflation factors, such as facility rent increases.

2) The above procedure would be used to calculate an aggregate current level budget for contracts by provider type (not by individual facility or contractor) that would then be funded in much the same way state agency budgets are funded. Other appropriate provider revenue sources (eg., resident room and board payments and fees-for-service received from other entities purchasing services from the provider) would be estimated and applied against the current level budget to ensure that the state funds only its share of increased costs. The legislature would then review the adjusted current level budgets in the same way it reviews state agency current level budgets and make revisions as necessary.

3) If state employee pay increases are granted and the legislature wishes to appropriate additional funding to providers for salary increases, the required amount would be based on estimated costs generated during current level analysis and would be added to any inflationary increases already included in the current level budget.

4) To avoid the risk of developing an employer-employee relationship with these providers, the current level budgeting methodology and any consideration of provider salary increases would be limited to developing aggregate funding levels only. The actual allocation of funds to individual providers would be at the discretion of the responsible state agency. Because a current level budgeting methodology may eliminate the need for across-the-board percentage increases (that imply the same increase for every individual provider), it may provide state agencies with more flexibility to "manage" their provider contracts.

<u>Medicaid services</u> - The complexities of federal medicaid rules and the broad diversity of provider groups participating in the program prevent the development of a single budgeting methodology to recognize provider cost increases. Rates for the two largest components of the medicaid program-- inpatient medical hospital and nursing facility services--are periodically reviewed by SRS to determine if they are "adequate and reasonable" as required by federal law. Even if the executive does not request rate increases based on the results of the review, the process ensures that the legislature has the necessary information if it wishes to consider rate increases, and it permits the legislature to make the final decision on the rates.

The legislature may wish to review existing budgeting and rate-setting policies for other medicaid services by:

1) requesting that SRS review its policy of increasing medicaid rates for certain cost-based services without legislative authorization. Rates for services such as

inpatient psychiatric, outpatient hospital, personal care, and mental health centers may be increased administratively without any review or input by the legislature. When this occurs, the legislature is denied an opportunity to establish its own priorities for rate increases and its ability to control medicaid costs may be reduced.

2) requesting that SRS review its rates for fee-based providers (such as physicians, dentists, pharmacist, and other practitioners) to determine if the rates are adequate. There is currently no systematic process for reviewing or increasing rates to this group of providers. Unless SRS periodically reviews these rates and reports its findings to the legislature, these providers may not receive rate increases at all. Or, if the legislature wishes to grant increases in the absence of an executive request, it may not have the information it needs to determine the appropriate level of increase.

Because there are so many fee-based medicaid providers throughout the state, it would be impossible for the agency to compare medicaid rates paid to providers with the costs they incur providing the service. However, an analysis of the following questions may provide meaningful information for the legislature to consider: a) have medicaid rates for the services most frequently purchased from these providers remained relatively constant as a percentage of their billable rates in recent years?; b) have the billable rate increases been in line with national medical inflation statistics?; and c) are significant numbers of these providers declining to participate in the medicaid program because the rates are inadequate?

ISSUES AND OPTIONS

ISSUE 1: SHOULD THE STATE DEVELOP A CURRENT LEVEL BUDGETING METHODOLOGY FOR NON-MEDICAID HUMAN SERVICE PROVIDER CONTRACTS REFLECTING ESTIMATED INCREASED COSTS?

Option A: Insert language in the 1995 biennium general appropriations act requiring the OBPP, LFA, and responsible state agencies to meet with representatives of these provider groups to: 1) determine the feasibility of developing such a system; 2) the numbers and types of providers and services for which such a budgeting system would be appropriate; and 3) report to the Legislative Finance Committee prior to February 1, 1994, on the feasibility of developing a current level 1997 biennium budget for these providers and services reflecting the state's share of increased costs. (This option would permit the committee to review the feasibility of the budgeting system and recommend a course of action.)

Option B: Insert language in the 1995 biennium general appropriations act requiring the OBPP, LFA, and responsible state agencies to:

1) meet with representatives of these provider groups to a) determine the feasibility of developing such a system; and b) the numbers and types of providers and services for which such a system would be appropriate; and

2) prepare a current level 1997 biennium budget for these providers and services reflecting the state's proper share of increased costs.

Option C: Take no action.

ISSUE 2: SHOULD THE STATE REVIEW ITS POLICY OF PROVIDING CERTAIN MEDICAID RATE INCREASES WITHOUT LEGISLATIVE AUTHORIZATION, WHILE REQUIRING ADDITIONAL FUNDING AND LEGISLATIVE AUTHORIZATION FOR OTHERS?

Option A: Request that SRS review its current policy of increasing certain cost-based medicaid rates without legislative authorization and report to the 1993 legislature by February 15, 1993, on the feasibility of subjecting those rate increases to the same legislative authorization required for most fee-based rate increases.

Option B: Take no action.

ISSUE 3: SHOULD THE STATE ESTABLISH A PERIODIC REVIEW OF RATES PAID MEDICAID PROVIDERS WHOSE RATE INCREASES MUST BE APPROVED BY THE LEGISLATURE TO ENSURE THAT THE RATES ARE EQUITABLE AND ADEQUATE?

Option A: Request that SRS prepare a report to the Legislative Finance Committee by July 1, 1993, on: 1) the feasibility of developing a methodology to determine the equity and adequacy of rates paid these providers for the services they most frequently deliver to medicaid recipients; and 2) the appropriate intervals for such rate reviews to occur.

Option B: Take no action.

CVS3A:lt:prates11.92